

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2011

FORM APPROVED

OMB NO. 0938-0391

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|--|---|---|--|--|--|---|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/01/2011 | |
| NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN46202 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| S0000 | This visit was for a State licensure survey. Facility Number: 005408 Survey Date: 5-31-11/6-1-11 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor QA: clauglin 06/06/11 | | | S0000 | N/A | | |
| S0132 | 410 IAC 15-2.4-1 (b)(8) The governing body shall do the following: (8) Ensure surgical procedures are performed only by a physician, dentist, or podiatrist who is privileged to perform such procedures according to medical staff bylaws, regulations, and/or policies and procedures. Based on document review and interview, the governing body failed to ensure | | | S0132 | 1. A list of privileges for this credentialed individual will be placed on file. | | 08/01/2011 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | <p>privileges for 1 of 2 practitioners credentialed by the medical staff.</p> <p>Findings:</p> <p>1. Review of 2 medical staff member credential files indicated there was no request or approval of privileges for AH#1.</p> <p>2. Review of governing board minutes dated 1-21-11 indicated the governing board credentialed AH#1 but did not approve of any privileges for this allied health practitioner.</p> <p>3. On 6-1-11 at 2:15 pm upon interview, AH#1 indicated he occasionally performed some services for the facility on patients while they were still patients of the facility or were still on the premises of the facility.</p> <p>4. On 5-31-11 at 9:45 am, employee #A1 was requested to provide documentation of privileges approved by the governing board for AH#1 and no documentation was provided by exit.</p> | | | | <p>2. All members credentialed in the surgery center will have a list of privileges on file.</p> <p>3. Nick Hunter (Administration) responsible.</p> | | |

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| S0310 | <p>410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review, the facility failed to ensure 1 directly-provided service (nursing) was included in its quality assessment performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include the directly-provided service of nursing.</p> <p>2. On 6-1-11 at 2:00 pm, employee #A1 was requested to provide documentation of inclusion of the above service. No documentation was provided prior to exit and employee #A1, upon interview, indicated there was no documentation of inclusion of nursing.</p> | | | S0310 | <p>1. The Eye Specialists QAPI program will include the directly-provided service of nursing.</p> <p>2. Documentation of this service will be completed and placed on file.</p> <p>3. Patricia Pfeffer, D.O.N. responsible.</p> | | 08/01/2011 |

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| S0326 | <p>410 IAC 15-2.4-2(a)(3)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(3) All services performed in the center with regard to appropriateness of diagnoses and treatments related to a standard of care and anticipated or expected outcomes.</p> <p>Based on document review and interview, the facility failed to ensure review of 1 practitioner's service performed in the center with regard to appropriateness of treatments related to a standard of care.</p> <p>Findings:</p> <p>1. Review of governing board minutes dated 1-21-11 indicated the governing board credentialed AH#1, an allied health practitioner.</p> <p>2. Review of 2 medical staff member credential files indicated there was no review of service performed in the center with regard to appropriateness of treatments related to a standard of care for practitioner AH#1.</p> <p>3. On 6-1-11 at 2:15 pm upon interview, AH#1 indicated he occasionally performed some services for the facility on patients while they were still patents of</p> | | | S0326 | <p>1. An up-to-date review of service performed in the surgery center with regard to appropriateness of treatments related to standard of care will be placed on file.</p> <p>2. All reviews will be placed in appropriate employee files in the future</p> <p>3. Nick Hunter (Administration) responsible.</p> | | 08/01/2011 |

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| | <p>the facility or were still on the premises of the facility.</p> <p>4. On 5-31-11 at 9:45 am, employee #A1 was requested to provide documentation of review of the service performed in the center with regard to appropriateness of treatments related to a standard of care for practitioner AH#1. No documentation was provided prior to exit.</p> | | | | | | |

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| S0442 | <p>410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on document review and interview, the facility failed to ensure that the employee health program determined the communicable disease history of new personnel for 4 of 9 employee files reviewed (Staff #2, 3, 5 and 8).</p> <p>Findings include:</p> <p>1. Review of staff #2, 3, 5 and 8's personnel files indicated lack of documentation of communicable disease history of items such as rubella, rubeola and varicella.</p> <p>2. On 05-31-11 at 1310 hours, staff #40 confirmed that the facility does not get titers or immunization history for rubella,</p> | | | S0442 | <p>1. Documentation of communicable disease history will be obtained and placed in appropriate employee files.</p> <p>2. Prior to hiring, all employees will need to provide documentation of communicable disease history for their file.</p> <p>3. Nick Hunter (Administration) responsible.</p> | | 08/01/2011 |

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| S0472 | <p>rubeola and varicella of new employees.</p> <p>410 IAC 15-2.4-1(2)(h)</p> <p>(h) Environmental surfaces and equipment not requiring sterilization which have been contaminated by blood or other potentially infectious materials shall be cleaned then decontaminated in accordance with acceptable standards of practice and applicable state laws and rules, 410 IAC 1-4.</p> <p>Based on interview, observation and document review, the facility failed to ensure that environmental surfaces which have been contaminated by blood or other potentially infectious materials are cleaned then decontaminated in accordance with acceptable standards of practice and applicable state laws and rules, 410 IAC 1-4.</p> <p>Findings include:</p> <p>1. Review of the Indiana Rule 4, Universal Precautions, 410 IAC 1-4, indicated the following: "(4) Environmental surfaces and equipment not requiring sterilization that have been contaminated by blood or other potentially infectious materials shall be cleaned with an absorbent material before disinfection. Disinfectant solutions shall be either of the following: (A) A germicide registered with the</p> | | | S0472 | <p>1. The current cleaner will be replaced with a product that complies with EPA standards.</p> <p>2. ESI internal policy 80 will be complied with and checked.</p> <p>3. Thomas Stone responsible.</p> | | 08/01/2011 |

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| | <p>Environmental Protection Agency (EPA) for use as a hospital disinfectant and labeled tuberculocidal or registered germicide with specific inactivation claims against HIV and HBV.</p> <p>(B) A sodium hypochlorite solution dated and not used after twenty-four (24) hours old as follows:</p> <p>(i) A minimum of 1:100 dilution (one-quarter (1/4) cup of five and twenty-five hundredths percent (5.25%) common household bleach in one (1) gallon of water).</p> <p>(ii) A 1:10 dilution (one (1) part five and twenty-five hundredths percent (5.25%) common household bleach in ten (10) parts water) shall be used when a blood, culture, or OPIM spill occurs in the laboratory setting."</p> <p>2. Review of policy/procedure 80, Housekeeping, indicated the following: "The floor is cleaned, using a bucket with approved detergent germicide and a clean mop head. This policy/procedure was last reviewed/revised on 01-2011.</p> <p>3. On 05-31-11 at 1525 hours, staff #45 confirmed that Select Bestever PH7 Lemon Cleaner is used to clean the operating room floors.</p> <p>4. Review of the Select Bestever PH7</p> | | | | | | |

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| S0630 | <p>Lemon Cleaner's manufacturer's label indicated lack of documentation that the product was a germicide registered with the Environmental Protection Agency (EPA) for use as a hospital disinfectant and labeled tuberculocidal or registered germicide with specific inactivation claims against HIV and HBV.</p> <p>410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on interview and document review, the facility failed to ensure that the medical record (MR) contained sufficient information to document accurately the course of the patient's stay in the center and the results of medications administered for 30 of 30 MRs reviewed (Patient #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30).</p> <p>Findings include:</p> <p>1. On 06-01-11 at 1050 hours, staff #40 confirmed that nursing staff give the</p> | | | S0630 | <p>1. Unable to correct deficiencies found in reviewed charts.</p> <p>2. All future patient records will accurately reflect all medications given prior to surgery. A section for recording the medications will be included in the patient's perioperative report and placed in the medical chart. This will be audited by Susan Brown, a contracted RN reviewer, using 30 charts on a quarterly basis. This will then be reported in our QAPI reports.</p> <p>3. Patricia Pfeffer, D.O.N. responsible.</p> | | 08/01/2011 |

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| | following preoperative medications prior to cataract surgery: Tropicamide ophthalmic solution for dilation of the eye. Proparacaine Hydrochloride to dye the eye. Ofloxacin an antibiotic. Isopto Homatrophine 5% for eye dilation. Review of patient #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30's MR indicated that each had cataract surgery and lacked documentation of Tropicamide ophthalmic solution, Proparacaine Hydrochloride, Ofloxacin and Isopto Homatrophine 5% being administered. | | | | | | |

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| S1154 | <p>410 IAC 15-2.5-7(b)(3)(C)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Operational and maintenance control records must be established and analyzed at least triennially. These records must be readily available on the premises.</p> <p>Based on document review, the facility failed to document operational and maintenance control records for the heating, ventilation, and air conditioning (HVAC) and fire alarm systems being analyzed at least triennially.</p> <p>Findings:</p> <p>1. On 5-31-11 at 9:45 am, employee #A2 was requested to provide documentation of triennial analysis of HVAC and fire alarm systems against manufacturer's recommendation or facility policy.</p> <p>2. No documentation was provided prior to exit.</p> | | | S1154 | <p>1. A review of the HVAC system will be performed by a qualified inspector according to manufacturer's recommendation.</p> <p>2. This inspection will be performed on a triennial basis.</p> <p>3. Nick Hunter (Administration) responsible.</p> | | 08/01/2011 |

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| S1168 | <p>410 IAC 15-2.5-7(b)(4)(B)(iii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the facility failed to document triennial analysis of patient care equipment checks against manufacturer's recommendation or facility policy, pertaining to equipment maintenance, repairs, and electrical current leakage checks, for 3 pieces of equipment.</p> <p>Findings:</p> | | | S1168 | <p>1. Documentation from K & R Medical showing patient care equipment checks was available but not on site at time of survey.</p> <p>2. Such documentation has been obtained and is currently on file.</p> <p>3. Patricia Pfeffer, D.O.N. responsible.</p> | | 06/02/2011 |

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| S1182 | <p>1. On 5-31-11 at 9:45 am, employee #A2 was requested to provide documentation of triennial analysis of patient care equipment checks against manufacturer's recommendation or facility policy, pertaining to equipment maintenance, repairs, and electrical current leakage checks, for a patient stretcher, sterilizer and suction machine.</p> <p>2. No documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based on document review, the facility failed to ensure an on-going center-wide process to evaluate and collect information about hazards and safety practices and ensure the results were reviewed by the appropriate safety committee.</p> <p>Findings:</p> <p>1. On 5-31-11 at 9:45 am, employee #A2</p> | | | S1182 | <p>1. A facility wide safety inspection will be conducted to assess any areas for improvement. 2. This will be done on an annual basis, added to our policy and procedures, and reported in the Safety Committee minutes. 3. Nick Hunter (Administration) responsible.</p> | | 08/01/2011 |

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| S1196 | <p>was requested to provide documentation of an on-going center-wide process to evaluate and collect information about hazards and safety practices and its review by the appropriate safety committee. No documentation was provided prior to exit.</p> <p>410 IAc 15-2.5-7(c)(5)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(5) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with center policy and state and local regulations.</p> <p>Based on document review, the facility failed to maintain documentation of regular inspection and approval of the facility by a state or local fire control agency.</p> <p>Findings:</p> <p>1. On 5-31-11 at 9:34 am, employee #A2 was requested to provide documentation of a State or local fire inspection or request for same in the past year. No documentation was provided prior to exit.</p> | | | S1196 | <p>1. A state fire inspection was requested by Nick Hunter on 6/2/2011. Inspection was completed on 6/10/2011 but an official report has not been received to date. Once obtained it will be filed.</p> <p>2. Administration will request a fire inspection in the event the state does not complete an inspection within one year of the most recent documentation.</p> <p>3. Nick Hunter (Administration) responsible.</p> | | 06/10/2011 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/27/2011

FORM APPROVED

OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 06/01/2011 | |
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